STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 01 B. WING	04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/18/12 Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, University Park Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 05/18/2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 104 and had a census of 82 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect the 2 residents in resident room 315 on the Memory Care hall. Findings include: Based on an observation with the Maintenance Supervisor on 04/18/12 at 1:00 p.m., the side A closet in resident room 315 has a one and one half inch hole in the ceiling at the side of the sprinkler head. This was acknowledged by the Maintenance Supervisor at the	K0025	**K 025 -** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. The two residents that reside in resident room 315 were not affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The identified one and one half inch hole in the ceiling at the side of the sprinkler head was filled by the facility Maintenance Director. **What measures will be put into place or what systemic changes will be made to ensure that the**	05/18/2012

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	time of observation. 3.1-19(b)		**deficient practice does not recur:** A facility audit was conducted by the Maintenance Director to ensure the smoke barriers were compliant with this alleged deficient practice throughout the facility. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** The Preventive Maintenance system TELs was updated to include resident rooms, storage rooms, and office space to inspect smoke barriers to ensure ongoing compliance. Findings will be reported to the Executive Director for review and follow up. The Maintenance Director will complete weekly inspections x 3 months and then monthly x 3 months or until substantial compliance. **By what date the systemic changes will be completed:** Compliance Date = 05/18/2012	

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K0056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 3 of 5 sprinkler heads in the employee lounge were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any number of staff in the employee lounge in the event of a fire emergency. Findings include: Based on observation with the Maintenance Supervisor on 04/18/12 at 1:55 p.m., three of the five sprinkler heads in the	K0056	**K 056** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this provider to ensure the automatic sprinkler system is installed in accordance with NFPA 13, the standard for the installation of Sprinkler Systems, and to provide complete coverage for all portions of the building. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents or employees were identified to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	05/18/2012

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	employee lounge were mounted near the employee lounge entrance door. The center sprinkler head was located four feet from the sprinkler head to the right and four feet from the sprinkler head to the left. Measurements were provided by the Maintenance Supervisor. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		All residents or employee have the potential to be affected by this alleged deficient practice. The identified sprinkler head was removed from the employee break room. Maintenance Director conducted a facility audit of the Sprinkler Heads throughout the facility to ensure all sprinkler heads are no closer than 6 feet apart. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** The Maintenance Director completed a facility audit of all sprinkler heads to ensure facility wide compliance. Findings were reported to the Executive Director for follow and review. **By what date the systemic changes will be completed:** Compliance Date = 05/18/2012	

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K0074 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure window curtains at 6 of 6 windows in the Memory Care dining room were flame retardant. This deficient practice could affect any of the 20 residents in Memory Care. Findings include: Based on observations with the Maintenance Supervisor on 04/18/12 at 1:06 p.m., the window curtains in the Memory Care dining room lacked attached	K0074	**K 074** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this provider to ensure draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in healthcare occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. The twenty residents identified on the facility Memory Care Unit had the potential to be affected by this alleged deficient practice. **How other residents having the potential to be affected by the**	05/18/2012

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	documentation confirming they were inherently flame retardant. Based on interview with the Maintenance Supervisor at 2:40 p.m. on 04/18/12, there was no documentation regarding flame retardancy for these window curtains available for review. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director treated the 6 identified curtains in the Memory Care Unit with a fire retardant spray. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director completed a facility audit all of window treatments to ensure all curtains have the proper fire spread identified on them. The curtains that did not have an identified fire spread rating were treated with a Fire Retardant spray. All curtains will be marked by the Maintenance Director to indicated the material was treated with the fire retardant spray or have a lable from the manufactor indicating the proper fire spread rating. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** The Maintenance Director will keep a tracking log with all identified curtains to ensure the material has been treated with the fire retardant spray or meets the proper fire spread rating. The Maintenance Director in-serviced facility staff to	

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			ensure new material is treated with the spray or has a label identifying the proper fire spread rating. The facility Preventive Maintenance program was updated to ensure routine inspections of the window treatments to ensure ongoing compliance. **By what date the systemic changes will be completed:** Compliance Date = 05/18/2012	

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K0130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 2 of 4 penetrations of the fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item	K0130	**K 130 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this provider to ensure the fire barrier walls are protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The 2 identified penetrations were repaired by the Maintenance Director.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A facility inspection was completed by the Maintenance Director ensure all Fire Barrier walls are free of penetrations to ensure facility wide compliance.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** The facility Preventive Maintenance program was updated to ensure routine	05/18/2012

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	uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect two of six smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor on 04/18/12 at 1:45 p.m., the main hall attic fire barrier wall had an unsealed penetration measuring two inches around electrical wires and a four inch gap around metal conduit. Measurements were provided by the Maintenance Supervisor. Based on an interview with the Maintenance Supervisor time of observation, this wall was a fire barrier wall. 3.1-19(b)		inspections of the facility fire barriers are completed to ensure ongoing compliance. Findings will be reported to the Executive Director for review and follow up.**By what date the systemic changes will be completed:** Compliance Date = 05/18/2012	